Healthy Michigan Plan (HMP) Second Waiver Comments submitted to CMS

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Submitted by Richard Teets, 160 Vorn Lane, Bloomfield Hills, MI 48301
richard.teets@gmail.com

Note: the author is a volunteer Navigator under the Affordable Care Act (ACA) with experience helping people sign up for the Healthy Michigan Plan. He is also an advocate for better health policy through the Metro Coalition of Congregations, a project of the Harriet Tubman Center and a member of Michigan Consumers for Healthcare. He is also on the board of a small healthcare foundation, the Metro Health Foundation. The following comments are based on his experience with these organizations, but do not necessarily represent the official opinion of these organizations.

Summary:
The waiver must have some features that CMS might find unacceptable because they set a precedent that other states might extend to create inferior programs. To counter this problem, the waiver should spell out the mitigating features of the Healthy Michigan Plan (HMP). The waiver will apply to target enrollees with incomes above 100% of the Federal Poverty Level and who have been in the plan for more than 48 cumulative months. The waiver must ask for unreasonably high limits on cost sharing by the enrollee, up to 7% of income. One mitigating factor is the relatively low copays. These make it likely that most enrollees will have cumulative copays that are less than 2% of income. Although the waiver must specify a "premium" of 3.5%, the state law allows this to be reduced for consumers who demonstrate "healthy behavior". The waiver should commit the state to a "premium" of 1% for people who meet the statutory requirement of an annual health risk assessment and adoption of one of a set of healthy behaviors. Enrollees who have been in the program for 48 months will have had plenty of time to learn how the systems works, and can therefore be expected to meet the requirements for healthy behaviors. In this way, enrollees in the target income range will typically keep their total cost sharing below 2 or 3%. Relatively few enrollees would reach 4%.

Discussion:
The law that expanded eligibility for Medicaid in Michigan contains a requirement for two waivers from the federal government (CMS – Centers for Medicare and Medicaid Services). The first waiver has already been granted. Through an excellent implementation from the Michigan Department of Health and Human Services (MDHHS), the Healthy Michigan Plan seems to me to be a very good model for Medicaid.

The second waiver requires some features that seem to be unreasonable in terms of providing cost effective care for the target population. For that reason, CMS may not be willing to grant this waiver. Unfortunately, if the waiver is not granted, the Healthy Michigan Plan will end, terminating the coverage for 600,000 enrollees. While the Michigan legislature *might* be willing to change the law, the partisan nature of health insurance discussions means that we cannot be sure of a good outcome.

I believe there is a straightforward way to design the waiver which might be acceptable to CMS and meet the requirement of the Michigan Law. It might even provide a model program for other states. The key features of the 2nd waiver are a change in the rules for people who have been on Medicaid for more than 48 months (cumulative) and who currently have income above 100% of the Federal Poverty Level (FPL). These people would be allowed to buy insurance on the Marketplace of the Affordable Care Act (ACA) with Advanced Premium Tax Credits and cost sharing reductions. Alternatively, they could stay in the Healthy Michigan Plan with possible contributions toward their healthcare of up to 7% of their income. This would include copays and 3.5% of income charged as a contribution (essentially a premium).

Many of us with experience dealing with the target population for this waiver (people with incomes between 100 and 138% of the FPL) realize that the 3.5% contribution would be a significant barrier to participation in the program. In addition, the idea that people with low incomes can budget 7% of their income for healthcare seems completely inconsistent with reality. Fortunately, the Michigan law and the DHHS current implementation provide a good way to make the Healthy Michigan Plan continue to work well for people with low incomes.

The first key is that the law allows the 3.5% contribution to be reduced, provided the enrollee fills out an annual health risk assessment and engages in healthy behaviors. The law does not put a lower limit on the required contribution. In the current implementation, the upper limit is 2%, but if the enrollee does the health risk assessment and adopts one healthy behavior, the contribution is dropped to 1%. The Health Risk Assessment can easily be done during an annual physical. Healthy behaviors include getting a flu shot or agreeing to *try* to stop smoking or to *try* to lose weight. The MDHHS apparently recognizes that it is better to set relatively easy targets and have people achieve them rather than set impossible targets. For this reason, it appears that enrollees who are reasonably responsible can easily reduce their required contribution to 1%.

I propose that the waiver describe the healthy behavior and health risk assessment component, and keep the same program for the enrollees who pass the 48 month milestone and exceed the 100% FPL limit. In particular, enrollees who do an annual health risk assessment and who engage in one healthy behavior should have a required contribution equal to 1% of income. Those who do not should have to contribute 3.5% of income. (There could be an exception for people with cognitive or mental health problems that make them incapable of meeting the requirements.)

Within this program, the 48 month limit makes sense. People who have been enrolled in the Healthy Michigan Plan for more than 48 months should have had plenty of time to understand the process for health risk assessment and adoption of a healthy behavior. For those that continue to ignore this option, it makes some sense to increase the penalty to 3.5% of income instead of 2% of income.

The state law requires that the upper limit on cost sharing be set at 7% for the target enrollees. This is a very high number, but in practice it will rarely, if ever be reached. That is because the copays in the Healthy Michigan Plan are set at a low level. The copays are set at $1 to $3, except for a copay for hospital admission of $50. In addition, copays are set to zero for

treatments related to chronic conditions and in cases where the copay could cause the enrollee to avoid needed care. Also, enrollees who go to Federally Qualified Health Centers do not usually have to pay the copay. For these reasons, many of the target enrollees would have cumulative copays less than 1% of income, and relatively few would have copays above 2% of income. (For a single person, 1% of FPL is $118. It takes many $2 copays to add up to $118). The state law allows MDHHS to reduce copays based on healthy behavior once the copays reach 3%. Thus while the law requires an upper limit of 7% cost sharing, for people who are willing to choose relatively simple healthy behaviors, the practical upper limit could be 4% (a "premium" of 1% and copays of 3% or less). Few people would actually even reach this limit, and it seems plausible that private grants could create a charity program that would cover enrollee costs above 3% of income. People who have had HMP for 48 months will have had time to learn the rules for HMP and should be able to minimize their cumulative copays and minimize their required premium.

Another important aspect of the Healthy Michigan Program is that enrollees cannot be terminated from coverage if they do not make payments. And the enrollee does not have to pay any copay at the time of service. Both the copays and the required contributions are channeled through a health account. The law allows the state to "garnishee" tax refunds to pay any money owed to the health account. And the law allows changes in some of the rules to induce enrollees to make payments that they owe. But these features are unlikely to cause many people to drop out of the Healthy Michigan Plan.

We must also consider the requirement that target enrollees be allowed to sign up for ACA insurance. For enrollees in this income range, there are currently silver plans available in metro Detroit that would be barely affordable. The network of providers for these low cost silver plans is probably comparable to or inferior to the network of providers for the Healthy Michigan Plan. Also, these plans do not include dental coverage while the Healthy Michigan Plan does. And the out-of-pocket risk for these plans significantly exceeds the likely out-of-pocket costs for HMP. For these reasons, relatively few people would choose ACA insurance over the Healthy Michigan Plan.

I cannot really address the potential increased cost to the federal government if people are allowed to sign up for ACA insurance instead of the Healthy Michigan Plan. As a Navigator, I have met some people in this income range (100-138% of FPL) who would prefer to have ACA insurance because of the stigma of Medicaid or because they are willing to use some assets to buy more expensive ACA insurance with a better network of providers. However, I believe that most people would view the Healthy Michigan Plan as a better choice, so the impact of this waiver on the federal deficit should be very minor. Indeed, in states that have good Medicaid plans, it might be reasonable to allow everyone in the 100-138% of FPL range to choose either Medicaid or ACA insurance with tax credits and cost sharing reductions. Most would choose Medicaid, but people who are near the 138% limit and have variable incomes might prefer the continuity of staying on an ACA plan. And people who temporarily have low incomes might prefer ACA insurance and continuity of care.

As discussed above, the state law allows a reasonable implementation of the waiver while still meeting the traditional goals and restrictions of Medicaid. However, if the state DHHS changed the implementation, the result could be a program that does not meet the goals of Medicaid and does not provide reasonable options for Michigan citizens with income between 100-138% of the FPL. For example, the state could make it difficult to meet the healthy behaviors requirement, so that many people would need to pay 3.5% of income as a premium. Similarly, the state could raise the copays to $10 or more, so that cumulative copays could become a significant barrier to care. For this reason, I believe the waiver should put some constraints on the copays and the rules for healthy behaviors. In my opinion, one can justify a 48 month time limit for a person to develop responsible, healthy behaviors if those behaviors are not too difficult. If the person does not learn to be responsible in that time period, it is reasonable to increase the penalty for irresponsible behavior. I believe the 7% limit on cost sharing is unreasonably high. Unfortunately, it is in the state law and may be very difficult to change. If the copays are limited to the $1-3 range and healthy behaviors can reduce the premium to 1%, I believe that very few people will exceed 4% total cost sharing.